Report to the Legislature

Final Report: Epidemic Disease Preparedness and Response for Long-Term Care Facilities

July 2022

SHB 1218 (2021)

Jointly prepared by:

Washington State Department of Social and Health Services (DSHS)

Washington State Department of Health (DOH)

Washington State Department of Social & Health Services

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Executive Summary

Substitute House Bill 1218; Chapter 159, Laws of 2021 (SHB 1218) was adopted May 3, 2021, to improve the health, safety, and quality of life for residents and clients in certified and licensed long-term care (LTC) settings. This legislation requires the Department of Health (DOH) and the Department of Social and Health Services (DSHS), with input from key partners, to develop a joint report and guidelines on epidemic disease preparedness and response for those LTC settings. We submitted an interim report to the Legislature in January 2022. The final report is due July 1, 2022.

DOH and DSHS developed the interim report following extensive conversations with stakeholders in the form of facilitated large group meetings, small group discussions, individual interviews, and surveys. The interim report focused on the specific issues certified and licensed LTC settings in Washington state faced during the COVID-19 pandemic and identified associated needs as SHB 1218 required. It considered visitation policies, admission and discharge policies, access to personal protective equipment (PPE), resident well-being, resident cohorting and treatment, and contact tracing. It identified major challenges, best practices, and lessons learned about containment and mitigation strategies for controlling the spread of the infectious agent.

This final report builds on information gathered from stakeholders and needs identified in the interim report. It discusses the relationship between state guidelines and federal requirements, instances when guidance issued by different entities may conflict, and work underway to ensure the consistent application of emergency preparedness guidelines in LTC across Washington state. It considers options for targeting resources towards infection control when an epidemic disease outbreak impacts LTC facilities, and the needs of each LTC provider type. It also outlines a timeline and process for communicating and implementing the guidelines, and for maintaining and updating the guidelines in future.

The attached guidelines, developed by DSHS and DOH, are based on current evidence and best practice, and consider existing state and federal guidance and standards for LTC. Certified and licensed long-term care settings should use these guidelines to create policies and procedures specific to their settings that assist with mitigating and managing the effects of a potential epidemic outbreak.

The Relationship Between Federal Requirements and State Guidelines

SHB 1218 directs DOH and DSHS to ensure that corresponding federal rules and guidelines take precedence over state guidelines, and to avoid conflict between federal requirements and state guidelines. Avoiding conflict between federal requirements and state guidelines as the pandemic response continues, and during future epidemic disease outbreaks, will be challenging due to the complex regulatory system and the number of authorities issuing guidance on federal, state, and local levels. Guidelines that DOH and DSHS developed as a result of this legislation are based on current evidence and best practice; they consider existing state and federal guidance and standards for LTC.

The interim report developed as a result of this legislation discusses the challenges and needs associated with COVID-19 guidance conflicts in detail. Stakeholders completed a survey specific to guidance and regulatory conflicts to help DOH and DSHS understand the types of conflicts encountered most often and the issues that arose during attempted resolution. We included those survey results in the interim report.

Stakeholders responding to the Guidance Conflict Survey reported feeling overwhelmed by the volume and frequency of guidance issued, and not knowing where to go to access the most current guidance. In February 2022, DSHS transitioned from its COVID-specific Safe Start guidance to a Long-Term Care COVID Response Plan. The new plan recommends that providers follow CDC, DOH, and (if applicable) CMS guidance and provides links to the appropriate guidance from these authorities. This change will make it easier for LTC providers to understand which guidance applies to their facility type.

Stakeholders reported not having a clear understanding of who to contact to get guidance clarification, and 60 percent of survey respondents had to wait more than three days to receive clarity or resolution to their question about seemingly conflicting guidance. A clear communication plan or avenue for guidance conflict resolution will be important to providers in future public health emergencies.

One possible pathway could be the addition of a Guidance Conflict Rapid-Response Team to the larger response structure during a public health emergency. When a provider has concerns about regulatory or guidance language that appears contradictory, the rapid-response team would be consulted, and it would respond directly to the provider who shared the concern, ideally within 72 hours. Team composition could include representatives from:

- DOH Licensing and Certification, Disease Control and Health Statistics Office of Communicable Disease Epidemiology, and/or Science Officer or designee.
- DSHS – Licensing and Certification.
- Local Health Jurisdiction (LHJ) Medical Director or designee.

- Governor's Office designee when the issue concerns the details of a proclamation.
- State Emergency Management Division designee as needed, depending on emergency response communication structure in place.
- Department of Labor and Industries (if the issue affects worker health issues).
- Other subject matter experts, as needed.

This would give providers a way to report a possible conflict to DOH/DSHS. The team would assess and triage concerns with priority given to those that represent work-stoppages. The Rapid-Response Team would also address concerns that potentially involve multiple agencies or multiple providers and have regional implications (for example, LHJs need to be involved in the discussion). When resolved, the concern and response could be communicated to all providers via existing communication methods.

DOH and DSHS will continue to expand on this idea in future work with stakeholders to find solutions to the issue of guidance conflicts during a public health emergency.

Timeline and Process for Communication and Implementing the Guidelines

We will house the guidelines on the DSHS Aging and Long-Term Support Administration page and the DOH website will link to them.

Table 1: Timeline and Process for Communication and Implementation

Implementation Step	Action Items	Timeline
Communication and Promotion of Guidelines	DSHS and DOH will promote the guidelines through regular communication channels, including Dear Provider letters, GovDelivery email listservs, and regularly scheduled calls with partners. DSHS and DOH will ask long-term care associations to promote the guidelines to their membership. DSHS and DOH will ask long-term care Ombuds to share the guidelines with resident councils within facilities.	Upon submission of the guidelines to the Legislature

Training and Education	DOH and DSHS will provide training on implementation of the guidelines to the LTC community via webinar. Training will include suggestions for implementation at various facility types. Suggestions will be grounded in the reality of staff capacity and the availability of resources. DOH and DSHS will develop supplemental materials to assist facilities in implementation based on needs stakeholders identify.	Beginning one month after we submit the guidelines to the Legislature and annually following the regularly scheduled updates to the guidelines.
Feedback Collection	DSHS and DOH will collect feedback from facilities that implement the guidelines early to determine opportunities for revision or enhancement.	Beginning October 2022 (We may adjust the timeline for this step based on mitigating circumstances resulting in delays to earlier steps of the process)
Report and Guidelines Review and Revision	DSHS and DOH will establish workgroups as needed to revise the guidelines and provide additional information and context specific to different provider and facility types.	Beginning December 2022 and continuing annually

Options for Targeting Available Resources Towards Infection Control in LTC Facilities

The interim report developed as a result of this legislation included consideration of several physical and financial resources, many of which can be targeted towards infection control as LTC facilities continue to respond to COVID-19—or a future epidemic disease outbreak.

PPE and Testing Resources

During the development of the interim report, stakeholders identified several barriers to accessing personal protective equipment (PPE) early in the pandemic, including shortages that affected their ability to order from commercial suppliers until the supply chain stabilized. When available, access to county- and state-level emergency PPE stockpiles have been essential to keeping LTC residents and staff safe.

Many LTC facilities still experience challenges as of the writing of this report. On a January 2022 survey distributed to LTC facilities in WA, 61 percent of respondents indicated they were having difficulty obtaining enough PPE for staff from commercial suppliers because of high demand for supplies the Omicron surge created. Of the respondents, 22 percent were using CDC PPE

optimization strategies and engaging in strategic, limited reuse of supplies due to PPE shortages in their facilities.

Facilities trying to get PPE from county-level governmental stockpiles during the Omicron surge report being told there is no supply, supplies are low, LTC is not currently a high priority, or that local emergency management is no longer providing PPE because supplies are available on the regular market. When county-level emergency management can't supply PPE, they forward the request to the state; but survey respondents report that state supplies are also low, and orders may only be partially filled.

More than 269 million pieces of PPE were distributed across Washington from the state stockpile between March 2020 and October 2021, including 35 million respirator masks, 147 million gloves, and 8 million gowns. This support will be critical in future public health emergencies. We recommend creating a streamlined process for access to governmental stocks of PPE through emergency management because the process varies by county and is not always intuitive. Disease variants, like we experienced during the COVID-19 pandemic, may create waves and surges causing LTC facilities and others to need additional PPE support. State and local emergency management should be aware of these possibilities and avoid completely ending governmental support while a public health emergency continues. We also recommend that the Legislature consider measures to more quickly initiate or re-initiate standup of governmental stockpiles.

During the development of the interim report, stakeholders identified challenges to accessing COVID-19 testing resources. Testing was largely unavailable early in the pandemic, and many LTC facility types needed external support from LHJs and community testing resources. LTC facilities found it difficult to establish cohorting processes necessary for infection prevention and control without access to rapid and accurate testing. The swift production and distribution of rapid tests will be critical to early outbreak identification in future epidemic scenarios. State and local emergency management should prioritize LTC for testing support and supply distribution.

Financial Resources

The interim report contains an overview of funding streams in the long-term care system, including COVID-19 specific relief funds. Enhanced Federal Medical Assistance Percentages (FMAP) funds temporarily changed the split of Medicaid funding from the typical 50/50 between state and federal dollars (with some variations among programs) to a higher amount of federal dollars. Enhanced FMAP funding continued through September 30, 2022. Washington invested most of the additional federal match funds back into Medicaid rates, increasing the daily rate provided to some LTC facility types. Many providers used these funds to pay staff temporary emergency rates, which helped keep staff levels high and reduced turnover during a period of extreme uncertainty. In future epidemic disease outbreaks, using emergency funds to

provide hazard pay, in acknowledgment of staff risk, may again help to reduce turnover and keep facilities staffed to a level at which they can quickly implement recommended infection control measures.

Capacity Building

DOH was awarded funds from two CDC Epidemiology and Laboratory Capacity grants to build capacity for infection prevention and target resources towards infection control when epidemic disease outbreaks occur.

The Nursing Home & Long-term Care Facility Strike Team and Infrastructure Project (STRIKE) is one-time funding through July 2024 that supports LTC facilities during the ongoing COVID-19 response. STRIKE funds are intended to improve and sustain facility capacity to detect and respond to infectious disease while building and maintaining the infection prevention infrastructure necessary to support resident, staff, and visitor safety. With these funds, DOH will work to support short-term staffing needs in LTC while implementing longer-term solutions to improve staff retention and increase staff knowledge of infection prevention principles. DOH also will use funds to implement measures to support the prevention and reduction of exposure to respiratory pathogens in facilities through education and environmental controls, supporting the ability of facilities to respond to current and future epidemic disease outbreaks when airborne spread is a concern.

Strengthening Healthcare Associated Infections/Antibiotic Resistance Program Capacity (SHARP) is ongoing funding intended to support public health surveillance, outbreak response, and program and partner building. SHARP funds support work in all health care settings, including LTC, and are not COVID-19 focused. Specific activities and projects funded through SHARP will increase infection-control knowledge in local health partners and frontline health care workers across Washington. This will increase the state's infection prevention knowledge and capacity, which will also promote epidemic preparedness and response capability when outbreaks occur.

Ways to Consistently Apply Epidemic Preparedness and Response Guidelines Across Washington

DOH and DSHS encourage all LHJs and LTC facilities in Washington to be familiar with and follow epidemic preparedness and response guidelines developed as a result of SHB 1218 section 30.

There are strong similarities in planning for traditional emergencies (earthquakes, floods, wildfires, and so on) and planning for a public health emergency (epidemic or pandemic). Although the events may differ, the response to each is based in a core set of principles. Each are informed by assessments, communications, policy, and procedure, and require teaching,

training, and testing of the plan. Relationship-building in advance of the crisis is necessary to both processes. The COVID-19 pandemic has shown that preparations must include the possibility of co-occurring events; hurricanes, large-scale wildfires, floods, and tornados have all occurred during the pandemic, adding even greater demands to already challenging situations. Developing and maintaining an emergency response plan as the foundation of an epidemic response plan provides a stronger response when dealing with simultaneous events. The longer a public health emergency persists, the more likely it is that a co-occurring natural disaster will compound the situation.

Consistent application of epidemic preparedness and response guidelines across LTC facilities in Washington will not be possible without support and connection to resources. Many emergency preparedness resources exist that can be adapted to be specific to epidemic preparedness in a variety of LTC facility types. DSHS and DOH will build on existing relationships with emergency preparedness subject matter experts and draw on the expertise that already exists within the LTC community (many LTC facilities in Washington already engage in emergency preparedness work appropriate to their setting). Facilities that have more preparedness experience may find that these adapted resources can supplement their existing plans. And facilities new to epidemic preparedness may use these resources to implement the pieces of the guidelines that are relevant to their settings.

As of the writing of this report, DSHS is in the process of implementing additional sections of SHB 1218 related to emergency preparedness and response: Sections 5, 11, and 16 require assisted living facilities, nursing homes, and enhanced services facilities to develop and maintain comprehensive disaster preparedness plans that include considerations of infectious disease outbreaks and for DSHS to adopt rules governing these plans. DSHS is currently engaging stakeholders in a collaborative rulemaking process to develop draft rules that will go into effect December 2023. Future updates to the guidelines developed under Section 30 will take the adoption of these rules into consideration. Facility types included in Section 30, but not affected by the new rules, may be of particular focus in future revisions to the guidelines as DOH and DSHS work to support epidemic preparedness and response capabilities in these facilities.

Future Updates to the Guidelines

DOH and DSHS will review the report and guidelines annually beginning December 1, 2022, as the legislation requires. The two agencies will work to make necessary changes regarding COVID-19 or information about any emerging epidemic of public health concern. They also will engage with stakeholders to collect feedback on the guidelines and the effects of changing conditions in the field. They will provide the updated report and guidelines to the health care committees of the Legislature and may include recommendations for any needed statutory

changes.

Considerations for Unique Provider Types

The LTC system in Washington state is complex. It encompasses variety of facility types and service providers who may be regulated by and required to adhere to rules set by multiple state and/or federal entities. As the legislation directed, this report and associated guidelines include considerations for: licensed skilled nursing facilities, assisted living facilities, adult family homes, enhanced services facilities, certified community residential services and supports, and registered continuing care retirement communities. For ease of access, distribution, and revision, DOH and DSHS created one set of guidelines rather than different guidelines for varying provider types. We don't intend, however, for these guidelines to be a one-size-fits-all document. This legislation specifies provider types that vary widely in terms of size, funding sources, financial resources, staffing requirements, and the types of care residents or clients need. Modifications and adaptations based on the characteristics of a specific provider type are expected and encouraged, especially when in consultation with an infection preventionist and the provider's licensing authority or applicable LHJ. DOH and DSHS will provide training on the guidelines to providers, which will include suggestions for implementation in varying facility settings. We also will provide connections to resources and develop supplemental materials based on needs stakeholders identified.

In addition to the LTC entity types named above, this process also must consider in-home service providers. In-home service providers include Home Health (services provided by licensed, skilled practitioners such as registered nurses, physical therapists, occupational therapists, and speech therapists), Hospice (provided by licensed, skilled practitioners for end-of-life care), and Home Care (services provided by credentialed nursing assistants, home care assistants, and personal care workers) that enable elders to remain in their homes for as long as possible. All these services are provided on an ongoing basis in whatever residence the recipient considers their home, which can include LTC residential facilities. In-home service providers play an integral role in the LTC system and must be included in stakeholder processes, guideline development, and guideline education. Their presence in traditional LTC facility settings means they require a working knowledge of the guidelines these facilities follow as well as guidance for their own infection control and epidemic preparedness planning programs.

Conclusion

The LTC community faced significant challenges during the COVID-19 pandemic. DOH and DSHS have worked with LTC stakeholders to understand barriers and challenges, and to identify lessons learned, best practices, and future needs. This learning will be ongoing as the pandemic continues to evolve.

DOH and DSHS will continue to work with LTC stakeholders to maintain and update the epidemic disease preparedness and response guidelines developed as a result of this legislation. Through this collaboration we will support LTC preparedness for future epidemics, resulting in improved health, safety, and quality of life for all members of the LTC community.


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